NOTICE OF CHANGE FOR
FEDERALLY QUALIFIED HEALTH CENTER
RURAL HEALTH CENTER

TO: Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

FROM: _____
Provider Name

_____
Practice Address

_____
City State Zip

DATE: _____ **Provider Number:** _____

EFFECTIVE DATE OF CHANGE: _____

Please check all items that have changes.

- ☐ New name of practice: _____
- ☐ New mailing address of practice: _____

  _____
- ☐ New location of practice (street address): _____
- ☐ New IRS Number: _____ **(Attach W-9)**
- ☐ New Medicare number for: Part A: _____ for Part B: _____
- ☐ New telephone number: (____) _____
- ☐ New fax number: (____) _____
- ☐ New e-mail address: _____ Contact name: _____
- ☐ New rate: (**Attach rate notification letter from Blue Cross and Blue Shield**)
- ☐ Physician Services:
  Name Physician (s) and attending provider number no longer associated with practice

  _____

  _____

  _____

  New Physician (s) associated with practice
  Name Individual Medicaid No. SSN

  _____

  _____

  _____

☐ Dental Services:
( ) Adding dental services ( ) Change in Dentist ( ) Deleting dental services

Name of Dentist and attending provider number no longer associated with practice

_____

_____

New Dentist joining practice
Name Individual Medicaid No. SSN

_____

_____

☐ Pharmacy Services:
( ) Adding pharmacy services. Attach copy of pharmacy permit and DEA approval.
( ) Deleting pharmacy services
( ) Change in dispensing/managing pharmacist
(1) **Name of Pharmacist no longer associated with practice**

_____

(2) **Pharmacist(s)**
Name License No. Manager (yes or no)

_____

_____

_____

☐ Adding DME services. Attach copy of Medicare certification and Board of Pharmacy Permit.

☐ Adding visiting nurse (Home Health) services; Attach Medicare certification as a home health shortage area.

☐ CLIA certification for lab services; Attach copy of CLIA certificate.

☐ Other change (please explain)

I understand that this change information document constitutes an amendment to the Medicaid provider agreement and all provisions of the provider agreement remain in force subject to this amendment.

_____
Signature of Authorized Agent Date

_____ ( )
Typed Name and Title of Authorized Agent Telephone Number

DMA APPROVAL:

Accepted on _____ by _____

DMA Use Only

Keyed by _____

Date Keyed _____